June 21, 2023

The Honorable Morgan Griffith, Chair
2202 Rayburn House Office Building
U.S. House of Representatives
Washington, DC 20515

The Honorable Kathy Castor, Ranking Member
2052 Rayburn House Office Building
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith and Ranking Member Castor,

I am writing on behalf of the American Society of Anesthesiologists® (ASA) to express our continued grave concerns regarding the broken Medicare physician payment system and the Medicare Access and CHIP Reauthorization Act (MACRA). On behalf of our more than 55,000 members, we welcome the opportunity to work with Congress to address severely underfunded Medicare physician payments and the persistent challenges of MACRA. We support efforts to ensure anesthesiologists and other clinicians can be successful in Medicare quality programs as well as be paid appropriately for the care they provide to their patients. We encourage Congress to consider legislation aimed at strengthening Medicare payments and supporting those anesthesiologists and physician groups who are making good-faith efforts to participate in MACRA, improve patient care, and reduce costs.

ASA urges the following reforms:

1) Fix the broken Medicare physician payment mechanism.
   - Pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, that will add an annual inflation adjustment to the Medicare physician fee schedule.
   - Adopt changes to the Medicare budget neutrality mechanism.

2) Improve the Merit-based Incentive Payment System (MIPS).
   - Re-implement the exceptional performance bonus for MIPS beyond the 2023 performance year.
   - Provide sufficient funding for positive payment adjustments for those exceeding the performance threshold.
   - Commission a study on whether negative payment adjustments improve performance, quality of care, or costs.

3) Create meaningful opportunities for participation in Alternative Payment Models (APM).
• Ensure APM incentives are equitably divided among members of the patient’s care team.
• Direct the Centers for Medicare & Medicaid Services (CMS) to work with medical specialty societies to expand the use of current APMs and develop APMs that reflect surgical episodes of care.
• Delay any implementation of mandatory APM models until value-based payment systems are proven to be viable and sustainable or allow mandatory models to include an opt-out for physicians and their groups.

Fix the broken Medicare physician payment mechanism

For MACRA to be successful, Congress must act on fixing a broken Medicare physician payment system. Beyond the merits of value-based care, an inherent flaw lies with CMS’ insufficient payment for physician services. Because the Quality Payment Program (QPP) builds off the underlying Medicare fee-for-service payment, additional MIPS and MIPS Value-Pathway (MVP) incentives will only drive change and improvements in care if underlying payments and programs offer sufficient financial incentives. Decade after decade of payment cuts and freezes have resulted in payment rates that are unsustainable for physician practices. For anesthesiologists, the Medicare physician payment system is especially unsound, as current Medicare payment rates for our specialty are less than one-third of commercial rates. Any incentive that the QPP provides, whether through MIPS, MVPs, or APMs, will be modest or completely negated so long as these low Medicare payment rates exist for anesthesiologists.

Accordingly, we urge Congress to address the underlying flaws in the Medicare physician payment system. **As a first step, Congress should immediately consider and pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act.** This bipartisan legislation would align physician fees with other Medicare payment formulas by adding an annual inflation adjustment to the Medicare physician fee schedule. Reforms of the punitive budget neutrality requirements are also essential to ensure Medicare payments reflect current realities facing our physicians.

Improvements to Merit-based Incentive Payment System (MIPS)

The COVID-19 pandemic disrupted the MACRA timeline and several of its goals Congress initially envisioned in 2015. Congress and CMS should now take the opportunity to revisit long-term objectives for the QPP and make necessary reforms. The pandemic effectively eliminated expected payment incentives for physicians and reduced opportunities for physicians to move into APMs. Effective participation in the QPP, both before and during the pandemic, has resulted in real and significant costs for anesthesiologists, their groups, and third-party intermediaries like the Anesthesia Quality Institute (AQI) National Anesthesia Clinical Outcomes Registry (NACOR). Congress should take this opportunity to rethink how the program is structured in a post-pandemic environment and identify program objectives that reflect our new health care realities and priorities.
Many physicians and groups participating in MIPS are frustrated that the initial projection of positive payment adjustments for the highest-performing participants has not been realized. Since positive payment adjustments are capped by a scaling factor of 3x the negative adjustments, the incentives have unfortunately been quite low. Prior to the 2021 performance year, the highest existing positive adjustments fell short of 2%. Only recently did positive payments for the highest performers rise to 2.34%. This is exceptionally disappointing for groups, as these positive adjustments fail to cover the costs of implementing and maintaining MIPS reporting locally. In short, there simply isn’t a financial return on investment for groups to participate in MIPS, and oftentimes successful participation in the program can still result in overall negative costs. This is causing groups, including many small groups and private practices, to become less engaged or leave the MIPS program altogether.

At the same time, there is no public evidence that negative payment adjustments have improved care or group performance. In theory, MIPS creates a system of “winners and losers” in which negative payment adjustments for poorly performing groups fund the positive adjustments for the high-performing groups. This flawed approach pits physician groups against one another rather than fostering collaboration among physicians, nurses, and other health care professionals. The system requires “poor performance” for the QPP to operate. In practice, CMS has mitigated downside risk and limited the number of poor performers by using COVID-19 exceptions in recent years to accomplish this task. Only 1.88% of MIPS participants received a negative adjustment in 2020, and less than 0.31% received a negative adjustment in 2019. Congress should commission studies to determine whether negative payment adjustments result in higher scores in future performance years. The studies should determine if a -9% adjustment has negatively affected group finances and whether those negative adjustments actually led to administrative and clinical changes that resulted in a better quality of care.

With the majority of participant scores clustered near the mean or median performance threshold and few funds saved from negative adjustments, the ability to award positive payment adjustments is severely limited. The anesthesia groups most hurt by these policies are those that exceeded the performance threshold but received a payment bonus significantly less than the cost of participating in the program. In 2020, those scoring between 45.01 and 84.99 points (exceeding the performance threshold of 45 points but not earning the exceptional performance bonus) received a maximum payment bonus of just 0.01%. Congress should fund greater financial incentives for QPP participants, including those who exceed the performance threshold but fail to earn an exceptional bonus, which would encourage groups to continue participating or rejoin the QPP. Such an outcome was not only demoralizing for the groups but failed to justify the costs for a group to participate in the program. In that one year, thousands of groups spent time and money on administrative costs to implement the program, technological costs to engage vendors, and clinical costs where physicians were spending time optimizing their participation in MIPS when they could have been spending time delivering patient care. The most equitable and quality-centered solution is not to fully enable the “winners and losers” model with +9/-9% payment adjustments as initially envisioned. Rather, Congress should fully
fund MIPS and other QPP programs to financially incentivize those required to participate who strive to deliver a high quality of care. Funding a minimum positive payment adjustment within MIPS charts a more secure path to greater MIPS participation.

**Create meaningful opportunities for participation in Alternative Payment Models (APM)**

The lack of participation in APMs from specialties like anesthesiology demonstrates that one of MACRA’s goals has not been fully realized. Although some anesthesiologists have participated in APMs, the vast majority of anesthesiologists find themselves left out of APMs, including those APMs designed to include surgical episodes. We support congressional funding of studies aimed at providing a pathway for groups to move from MIPS to APMs (with or without the adoption of MVPs) and how CMS can adjust its policies to best facilitate these transitions. With research-backed recommendations, it would be easier for physicians and groups to understand their risks, chart a plan for joining a value-based payment system, and understand the financial benefits such a move would generate.

To increase anesthesiologist participation within value-based payment models, Congress should emphasize episode-based models and encourage CMS to holistically rethink how anesthesia and other specialties fit within those models. Because anesthesia care is episode-based and requires collaboration with other specialties, distinguishing anesthesia’s role in patient care from that of the other specialties is not always straightforward. If CMS can ensure that anesthesiologists are properly attributed across value-based payment systems, this would be a strong selling point for our members and specialty.

Congress should encourage multispecialty participation in APMs through appropriate financial structures. We also recommend adjusting the alignment of incentives to more accurately represent the totality of a patient’s care journey. For anesthesiologists, APM incentives could highlight the perioperative role anesthesiologists play in delivering patient-centered care. Anesthesiologists practice the full spectrum of perioperative medicine, and their many roles, including prehabilitating patients and coordinating care, serve as a significant cost-saver for facilities and payers. Unfortunately, such activities are not recognized in APM payments. A better accounting of multispecialty cases and perioperative care will enable greater incentives for anesthesiologists both to provide cost-saving care and to join APMs.

ASA recommends that Congress and CMS consider allotting a percentage of the APM savings to all contributing clinicians or provide some upfront direct payment to those clinicians (this latter approach is used by some Accountable Care Organizations [ACOs]). The Medicare Shared Savings Program has unfortunately resulted in some primary care physicians excluding specialists from ACOs. To address attrition, Congress could incentivize ACOs to include specialists through statutory requirements or through a score multiplier within the QPP.

ASA believes these proposed actions will increase physician participation in CMS’s value-based payment models. However, even if CMS encourages physician participation in APMs on a
widespread basis, value-based payment models may not be the optimal system for every physician or group. Particularly for small groups and private practice groups, the fee-for-service model could be more financially feasible without sacrificing quality of care. For this reason, we caution against the adoption of mandatory models. We believe any mandatory model must demonstrate financial stability and practicality for widespread adoption before becoming mandatory. If higher participation is needed to produce the data that would prove the models' viability, then this participation should be incentivized on a voluntary basis. If CMS reaches the point at which the models are proven viable and the agency wishes to make them mandatory, it would be appropriate to offer an opt-out for those groups that benefit the most from maintaining their existing payment models without sacrificing patient care or safety.

The COVID-19 pandemic distorted the timeline for MACRA that Congress initially envisioned. Congress and CMS should now take the opportunity to revisit long-term plans for the program, particularly as they pertain to the QPP.

Thank you for your consideration of our comments. We welcome the opportunity to speak with you further about our feedback. Please contact Manuel Bonilla, ASA Chief Advocacy Officer, at (202) 289-7045 or Nora Matus, ASA Director of Congressional Political Affairs, at (202) 591-3708 for questions or further information.

Sincerely,

Michael Champeau, MD, FASA
President
American Society of Anesthesiologists